U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 01 February 2007

Case No.: 2005-LHC-2211

OWCP No.: 07-164088

IN THE MATTER OF

D. B.,
Claimant

vs.

NORTHROP GRUMMAN SHIP SYSTEMS, INC./
AVONDALE INDUSTRIES, INC.,
Employer

APPEARANCES:

JEREMIAH A. SPRAGUE, ESQ.,
KENNETH WAGUESPACK, ESQ.,
On Behalf of the Claimant

FRANK J. TOWERS, ESQ.,
On Behalf of the Employer

BEFORE: PATRICK M. ROSENOW
Administrative Law Judge

DECISION AND ORDER

PROCEDURAL STATUS

This case arises from a claim for benefits under the Longshore Harbor Workers' Compensation Act (the Act),[1] brought by D.B. (Claimant) against Northrop Grumman Ship Systems, Inc./Avondale Industries, Inc. (Employer).

[1] 33 U.S.C. §901 *et seq.*

The matter was referred to the Office of Administrative Law Judges for a formal hearing. Both parties were represented by counsel. On 12 Jul 06, a hearing was held at which the parties were afforded a full opportunity to call and cross-examine witnesses, offer exhibits, make arguments, and submit post-hearing briefs.

My decision is based upon the entire record, which consists of the following:[2]

Witness Testimony of
Claimant
Claimant's Spouse
Michael Nebe

Exhibits
Claimant's Exhibits (CX) 1-6
Employer's Exhibits (EX) 1-15[3]
Joint Exhibit (JX) 1-2[4]

My findings and conclusions are based upon the stipulations of counsel, the evidence introduced, my observations of the demeanor of the witnesses, and the arguments presented.

STIPULATIONS[5]

1. Claimant was involved in an accident on 13 Feb 02.

2. The accident occurred in the course and scope of his employment as a longshoreman as defined under the Act.

3. There was an Employee/Employer relationship at the time of the accident.

4. There was proper and timely notice of the injury to Employer.

5. Employer filed a proper and timely notice of controversion.

[2] I have reviewed and considered all testimony and exhibits admitted into the record. Reviewing authorities should not infer from my specific citations to some portions of witness testimony and items of evidence that I did not consider those things not specifically mentioned or cited.
[3] Counsel were informed that since EX-7 and EX-10 are lengthy in globo medical records, only those parts of the exhibits specifically cited by Counsel on brief or at hearing would be considered part of the record upon which the Court would base its decision. Similarly, since EX-15 is a deposition of a witness testifying live at hearing, only those parts of the exhibit specifically cited by Counsel on brief or at hearing would be considered part of the record upon which the Court would base its decision. EX-6, which was identified in Employer's index as Dr. Awashthi's records, contained no pages. However, CX-1 was also identified as Dr. Awashthi's records and included 10 pages.
[4] Counsel submitted a tabular summary of medical care consistent with the court's pre-trial order post-hearing. It has been marked as JX-2.
[5] JX-1; Tr. 7-11.

6. Claimant's average weekly wage (AWW) was $591.20, with a total disability compensation rate of $394.15.

7. Claimant was paid the appropriate amounts of compensation for the following periods:

    a. Claimant was temporarily totally disabled from 14 Jun 02 to 22 Oct 02, 10 Aug 04 to 24 Oct 04, and 26 Oct 04 to 13 Feb 05.

    b. Claimant was temporarily partially disabled from 29 Apr 05 to 24 Dec 05.

FACTUAL BACKGROUND

On 13 Feb 02, Claimant fell while working for Employer. He injured his left shoulder and treated with Employer's medical staff. He returned to work with a sling, but continued having problems. Eventually, he was referred to an orthopedist, had an MRI, and was found to have suffered from a torn rotator cuff of the left shoulder. Claimant had surgery to repair the tear, but continued to complain of left arm pain and numbness during an extended post-surgery period. He was referred to a pain management specialist, who diagnosed him with carpal tunnel syndrome and prescribed medication and physical therapy. When the pain management physician noted facial weakness, she referred Claimant to a neurologist, who diagnosed Claimant with Bell's Palsy.

Claimant became frustrated with his lack of progress and retained his attorney, who sent him to a neurologist, Dr. Barratt. Employer refused to pay for his treatment with Dr. Barratt. She ordered a cervical MRI, which showed compression bulging at multiple levels. She referred Claimant to a neurosurgeon, who performed surgery on Claimant's spine.

ISSUES

Claimant contends that he is entitled to compensation for temporary total disability from 13 Feb 05 to 29 Apr 05 and from 24 Dec 05 to present and continuing. Employer responds that it paid Claimant total disability compensation benefits from 13 Feb 05 to 29 Apr 05 and Claimant's claim as to that period is moot. Employer also argues that it has established the availability of suitable alternative employment (SAE) from 24 Dec 05, to present and continuing.

Claimant argues that Dr. Barratt was his choice of physician and that his treatment with her and subsequent cervical surgery was reasonable and necessary medical care for a condition arising out of his injury on 13 Feb 02. Employer responds that the cervical treatment is not for a condition arising out of Claimant's injury on 13 Feb 02 and is not reasonable and necessary. Employer further submits that Claimant had already chosen his physician and did not require Dr. Barratt as an additional specialist.

LAW

Although the Act must be construed liberally in favor of the claimant,[6] the "true-doubt" rule, which resolves factual doubts in favor of the claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act,[7] which specifies that the proponent of a rule or position has the burden of proof and, thus, the burden of persuasion.[8]

In arriving at a decision in this matter, it is well-settled that the finder of fact is entitled to determine the credibility of witnesses, to weigh the evidence and draw his own inferences therefrom, and is not bound to accept the opinion or theory of any particular medical examiners.[9]

Compensable Injury

Section 2(2) of the Act defines "injury" as "accidental injury or death arising out of or in the course of employment."[10] In the absence of any substantial evidence to the contrary, the Act presumes that a claim comes within its provisions.[11] The presumption takes effect once the claimant establishes a *prima facie* case by proving that he suffered some harm or pain and that a work-related condition or accident occurred, which could have caused the harm.[12]

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[6] *Voris v. Eikel*, 346 U.S. 328, 333 (1953); *Britton*, 377 F.2d 144.
[7] 5 U.S.C. § 556(d).
[8] *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct 2251 (1994), *aff'g* 900 F.2d 730 (3rd Cir. 1993).
[9] *Duhagon v. Metropolitan Stevedore Co.*, 31 BRBS 98, 101 (1997); *Avondale Shipyards, Inc. v. Kennel*, 914 F.2d 88, 91 (5th Cir. 1988); *Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce*, 551 F.2d 898, 900 (5th Cir. 1981); *Bank v. Chicago Grain Trimmers Association, Inc.*, 390 U.S. 459, 467, *reh'g denied*, 391 U.S. 929 (1968).
[10] 33 U.S.C. § 902(2).
[11] 33 U.S.C. § 920(a).
[12] *Gooden v. Director, OWCP*, 135 F.3d 1066 (5th Cir. 1998).

A claimant need not affirmatively establish a causal connection between his work and the harm he has suffered, but rather need only show that: (1) he sustained physical harm or pain, and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain.[13] These two elements establish a *prima facie* case of a compensable "injury" supporting a claim for compensation.[14]

If the work injury aggravates a pre-existing condition, the aggravation is compensable under the Act. Employers accept their employees with the frailties which predispose them to bodily injury.[15]

The presumption does not apply, however, to the issue of whether a physical harm or injury occurred[16] and does not aid the claimant in establishing the nature and extent of disability.[17]

A claimant's credible subjective complaints of symptoms and pain can be sufficient to establish the element of physical harm necessary for a *prima facie* case and the invocation of the Section 20(a) presumption.[18]

Nature and Extent of Disability

Once it is determined that he suffered a compensable injury, the burden of proving the nature and extent of his disability rests with the claimant.[19] Disability is generally addressed in terms of its nature (permanent or temporary) and its extent (total or permanent). The permanency of any disability is a medical rather than an economic concept.

Disability is defined under the Act as an "incapacity to earn the wages which the employee was receiving at the time of injury in the same or any other employment."[20] Therefore, for a claimant to receive a disability award, an economic loss coupled with a physical and/or psychological impairment must be shown.[21] Thus, disability requires a

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[13] *Kelaita v. Triple A Machine Shop*, 13 BRBS 326 (1981), *aff'd sub nom. Kelaita v. Director, OWCP*, 799 F.2d 1308 (9th Cir. 1986); *Merrill v. Todd Pacific Shipyards Corp.*, 25 BRBS 140 (1991); *Stevens v. Tacoma Boat Building Co.*, 23 BRBS 191 (1990).
[14] *Id.*
[15] *J.B. Vozzolo, Inc. v. Britton*, 377 F.2d 144, 147-8 (D.C. Cir. 1967).
[16] *Devine v. Atlantic Container Lines, G.I.F.*, 25 BRBS 15 (1990).
[17] *Holton v. Independent Stevedoring Co.*, 14 BRBS 441 (1981); *Duncan v. Bethlehem Steel Corp.*, 12 BRBS 112 (1979).
[18] *See Sylvester v. Bethlehem Steel Corp.*, 14 BRBS 234, 236 (1981), *aff'd sub nom. Sylvester v. Director, OWCP*, 681 F.2d 359, 14 BRBS 984 (5th Cir. 1982).
[19] *Trask v. Lockheed Shipbuilding Construction Co.*, 17 BRBS 56, 59 (1980).
[20] 33 U.S.C. § 902(10).
[21] *Sproull*, 25 BRBS at 110.

causal connection between a worker's physical injury and his inability to obtain work. Under this standard, a claimant may be found to have either suffered no loss, a total loss or a partial loss of wage-earning capacity.

Permanent disability is a disability that has continued for a lengthy period of time and appears to be of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period.[22] A claimant's disability is permanent in nature if he has any residual disability after reaching maximum medical improvement.[23] Any disability suffered by Claimant before reaching maximum medical improvement is considered temporary in nature.[24]

The question of extent of disability is an economic as well as a medical concept.[25] To establish a *prima facie* case of total disability, the claimant must show that he is unable to return to his regular or usual employment due to his work-related injury.[26]

A claimant's present medical restrictions must be compared with the specific requirements of his usual or former employment to determine whether the claim is for temporary total or permanent total disability.[27] Once a claimant is capable of performing his usual employment, he suffers no loss of wage-earning capacity and is no longer disabled under the Act.

To establish a *prima facie* case of total disability, the employee need only show he cannot return to his regular or usual employment due to his work-related injury.[28] If the claimant makes this *prima facie* showing, the burden shifts to employer to show suitable alternative employment.[29] The presumption of disability ends on the earliest date that the employer establishes suitable alternate employment.[30]

The employer is liable only for the degree of disability attributable to the covered injury or its natural progression. It is not responsible for disability attributable to an independent intervening cause.[31]

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[22] *Watson v. Gulf Stevedore Corp.*, 400 F.2d 649, *pet. for reh'g denied sub nom. Young & Co. v. Shea*, 404 F.2d 1059 (5th Cir. 1968) (per curiam), *cert. denied*, 394 U.S. 876 (1969); *SGS Control Services v. Director, OWCP*, 86 F.3d 438, 444 (5th Cir. 1996).
[23] *Trask*, 17 BRBS at 60.
[24] *Berkstresser v. Washington Metropolitan Area Transit Authority*, 16 BRBS 231 (1984); *SGS Control Services*, 86 F.3d at 443.
[25] *Quick v. Martin*, 397 F.2d 644 (D.C. Cir. 1968); *Eastern S.S. Lines v. Monahan*, 110 F.2d 840 (1st Cir. 1940); *Rinaldi v. General Dynamics Corp.*, 25 BRBS 128, 131 (1991).
[26] *Elliott v. C & P Telephone Co.*, 16 BRBS 89 (1984); *Harrison v. Todd Pacific Shipyards Corp.*, 21 BRBS 339 (1988); *Louisiana Insurance Guaranty Ass'n v. Abbott*, 40 F.3d 122, 125 (5th Cir. 1994).
[27] *Curit v. Bath Iron Works Corp.*, 22 BRBS 100 (1988).
[28] *Elliot v. C & P Tel. Co.*, 16 BRBS 89 (1984).
[29] *Clophus v. Amoco Prod. Co.*, 21 BRBS 261 (1988); *Nguyen v. Ebbtide Fabricators*, 19 BRBS 142 (1986).
[30] *Palombo v. Director, OWCP*, 937 F.2d 70, 25 (2d Cir. 1991).
[31] *Wheeler v. Intercocean Stevedoring, Inc.*, 21 BRBS 33 (1988).

Suitable Alternative Employment

If the claimant is successful in establishing a *prima facie* case of total disability, the burden of proof is shifted to employer to establish suitable alternative employment.[32] Addressing the issue of job availability, the Fifth Circuit has developed a two-part test by which an employer can meet its burden:

> (1) Considering claimant's age, background, etc., what can the claimant physically and mentally do following his injury, that is, what types of jobs is he capable of performing or capable of being trained to do?
>
> (2) Within the category of jobs that the claimant is reasonably capable of performing, are there jobs reasonably available in the community for which the claimant is able to compete and which he reasonably and likely could secure?[33]

Employers need not find specific jobs for a claimant; instead, they may simply demonstrate "the availability of general job openings in certain fields in the surrounding community."[34] Employers may meet their burden by first introducing evidence of suitable alternate employment at the hearing,[35] even though such evidence may be suspect and found to be not credible.[36]

The relevant community is the community in which the injury occurred, but may include the area where the claimant resided at the time of injury.[37] If the claimant relocates for personal reasons, the employer can still meets its burden by demonstrating that jobs are available in the area in which the claimant resided at the time of the injury.[38]

The employer must establish the precise nature and terms of job opportunities it contends constitute suitable alternative employment in order to establish the claimant is physically and mentally capable of performing the work and that it is realistically available.[39] The administrative law judge must compare the jobs' requirements identified by the vocational expert with the claimant's physical and mental restrictions based on the

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[32] *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1038 (5th Cir. 1981).
[33] *Id*. at 1042.
[34] *P & M Crane Co. v. Hayes*, 930 F.2d 424, 431 (1991); *Avondale Shipyards, Inc. v. Guidry*, 967 F.2d 1039 (5th Cir. 1992).
[35] *Turney v. Bethlehem Steel Corp.*, 17 BRBS 232, 236-37 n.7 (1985).
[36] *Diamond M Drilling Co.*, 577 F.2d at 1007 n.5.
[37] *Jameson v. Marine Terminals*, 10 BRBS 194 (1979).
[38] *Elliot v. C & P Tel. Co.*, 16 BRBS 89, 92 (1984).
[39] *Piunti v. ITO Corporation of Baltimore*, 23 BRBS 367, 370 (1990); *Thompson v. Lockheed Shipbuilding & Construction Co.*, 21 BRBS 94, 97 (1988).

medical opinions of record.[40] A showing of only one job opportunity may suffice under appropriate circumstances.[41] Conversely, a showing of one unskilled job may not satisfy the employer's burden.

Once the employer demonstrates the existence of suitable alternative employment, the claimant can nonetheless establish total disability by demonstrating that he tried with reasonable diligence to secure such employment and was unsuccessful.[42] Thus, a claimant may be found totally disabled under the Act "when physically capable of performing certain work but otherwise unable to secure that particular kind of work."[43]

Medical Care and Benefits

Section 7(a) of the Act requires employers to provide reasonable and necessary medical care.[44]

Reasonableness and Necessity of Medical Treatment

Section 7(a) of the Act provides that:

> The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.[45]

An employer is liable for all medical expenses which are the natural and unavoidable result of a claimant's work injury. For medical expenses to be assessed against an employer, the expenses must be both reasonable and necessary.[46] Medical care must also be appropriate for the injury.[47]

A claimant has established a *prima facie* case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition.[48]

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[40] *Villasenor v. Marine Maintenance Industries, Inc.*, 17 BRBS 99 (1985); s*ee generally, Bryant v. Carolina Shipping Co., Inc.*, 25 BRBS 294 (1992); *Fox v. West State, Inc.*, 31 BRBS 118 (1997).
[41] *P & M Crane Co.*, 930 F.2d at 430.
[42] *Turner*, 661 F.2d at 1042-1043; *P & M Crane Co.*, 930 F.2d at 430.
[43] *Turner*, 661 F.2d at 1038, *quoting Diamond M. Drilling Co. v. Marshall*, 577 F.2d 1003 (5th Cir. 1978).
[44] 33 U.S.C. § 907(a).
[45] 33 U.S.C. § 907(a).
[46] *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979).
[47] 20 C.F.R. § 702.402.
[48] *Turner,* 16 BRBS at 257-258.

Section 7 does not require than an injury be economically disabling for a claimant to be entitled to medical benefits, but only that the injury be work-related and the medical treatment be appropriate for the injury.[49] Entitlement to medical benefits is never time-barred where a disability is related to a compensable injury.[50]

An employer is not liable for past medical expenses unless the claimant first requested authorization prior to obtaining medical treatment, except in the cases of emergency, neglect, or refusal.[51] Once an employer has refused treatment or neglected to act on claimant's request for a physician, the claimant is no longer obligated to seek authorization from employer and need only establish that the treatment subsequently procured on his own initiative was necessary for treatment of the injury.[52]

The employer's refusal need not be unreasonable for the employee to be released from the obligation of seeking his employer's authorization of medical treatment.[53] Refusal to authorize treatment or neglecting to provide treatment can only take place after there is an opportunity to provide care, such as after the claimant requests such care.[54] Furthermore, the mere knowledge of a claimant's injury does not establish neglect or refusal if the claimant never requested care.[55]

Choice of Physician

According to Section 7(b) of the Act, Claimant "shall have the right to choose an attending physician . . . If due to the nature of the injury, the employee is unable to select his physician and the nature of the injury requires immediate medical treatment and care, the employer shall select a physician for him."[56] Necessary immediate medical care contemplates severe injuries, unconsciousness, or other inability to select a physician.

After an initial choice of physician, a claimant may not change physicians without prior written consent of the employer or carrier.[57] An employer shall consent to a change in physician where claimant's initial free choice was not of a specialist whose services are necessary for and appropriate to, the proper care and treatment of the compensable injury.[58] Consent for change of physician may be given upon a showing of good cause.

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[49] *Ballesteros*, 20 BRBS at 187.
[50] *Weber v. Seattle Crescent Container Corp.*, 19 BRBS 146 (1980); *Wendler v. American National Red Cross*, 23 BRBS 408, 414 (1990).
[51] *Schoen v. U.S. Chamber of Commerce*, 30 BRBS 103 (1997); *Maryland Shipbuilding & Drydock Co. v. Jenkins*, 594 F.2d 404, 10 BRBS 1 (4th Cir. 1979), *rev'g* 6 BRBS 550 (1977).
[52] *Pirozzi v. Todd Shipyards Corp.*, 21 BRBS 294 (1988); *Rieche v. Tracor Marine*, 16 BRBS 272, 275 (1984).
[53] *See generally*, 33 U.S.C. § 907(d)(1)(A).
[54] *Mattox .v Sun Shipbuilding & Dry Dock Co.*, 15 BRBS 162 (1982).
[55] *Id*.
[56] 33 U.S.C. § 907(b).
[57] 33 U.S.C. § 907(c)(2).
[58] Id.

Claimant's treating physician may refer claimant to a specialist for services which are necessary for the proper care and treatment of his compensable injury.[59]

When an employer selected an employee's physician in an emergency, the employee may change physicians when he is able to make a selection.[60] Such changes must be made upon obtaining written authorization from the employer, or if consent is withheld, from the district director.[61] A claimant may select his choice of physician by his implicit acquiescence to continue treating with the physician and his subsequent referrals.[62]

EVIDENCE

Claimant testified at trial[63] and by deposition[64] in pertinent part that:

> He worked for Employer for twenty-eight years as a welder. On 13 Feb 02, he was inspecting a weld on a scaffold. He slipped and lost his balance. As he grabbed the lifeline he heard a snap in his arm and it gave away. He was holding on by one arm and fell to the deck.
>
> He went to the first-aid station, where he told Dr. Mabe what happened and that his arm was numb. When x-rays did not show anything they gave Claimant a sling, an icepack, and Ibuprofen and sent him back out to the yard. He kept checking back with the company medics everyday thereafter. In May, he still wore a sling because his arm was still swollen and they sent him to get an MRI.
>
> They sent him to West Jefferson Hospital where he saw Dr. Cashio. He told Dr. Cashio his arm was hurting and numb in the shoulder area. He did not tell Dr. Cashio his neck hurt. The MRI showed a torn rotator cuff and Dr. Cashio recommended surgery to repair it. Claimant had the surgery, but still had numbness in his arm. Dr. Cashio said he could not do anything for the numbness and referred Claimant to Dr. Colvin at the Culicchia Neurological Clinic.
>
> Claimant told Dr. Colvin about numbness in his arm that would go around to the other arm. He did not tell Dr. Colvin his neck hurt. Dr. Colvin treated him for carpal tunnel syndrome. She sent Claimant to physical therapy and prescribed Vicodin. He took Vicodin for about a year and one-half to two years. He treated with Dr. Colvin for two years. Dr. Colvin noticed that Claimant's face was

[59] 20 CFR § 702.406(a).
[60] 20 CFR § 702.405.
[61] 20 CFR § 702.405; *Bulone v. Universal Terminal & Stevedoring Corp.*, 8 BRBS 515 (1978).
[62] *Relying on* 20 CFR § 702.406(a); s*ee Senegal v. Strachan Shipping Co.*, 21 BRBS 8 (1988); *Hunt v. Newport News Shipbuilding and Dry Dock Co.*, 28 BRBS 364, 370-371 (1994).
[63] Tr. 27-47.
[64] EX-15, pp. 6-8, 34 (as cited, see fn. 3, *supra*).

twisted and thought Claimant may have had a stroke. She sent him to Dr. Truax at the Culicchia Neurological Clinic, who diagnosed him with Bell's Palsy. Employer sent Claimant for an evaluation regarding his left arm abilities. He was released back to work with a 50 pound lifting limit.

He was not happy that Employer was forcing him back to work because he could not lift with his left arm, so he retained his current counsel. His attorney advised him to see Dr. Diana Barratt. Employer refused to pay for Dr. Barratt, so Claimant used his group health insurance. Claimant told Dr. Barratt about his surgery and that his arm was numb and he could not raise it. He did not tell her his neck hurt. She immediately took x-rays of his neck and arm. She said he had a disc impingement his neck and referred him to Dr. Awasthi for surgery. Dr. Awasthi did the surgery and removed discs three, four, five and six and put two artificial bones and a plate in his neck. The surgery helped relieve some of the numbness.

Claimant had lived in Marrero, Louisiana for 25 years until Hurricane Katrina displaced him to Texas, where he still lives. He was in Houston, but three weeks before the hearing he moved to Pearland. He intends to live in Texas for at least the next year, if his wife keeps her current job at a church school. He has a twelfth-grade education and graduated from high school in 1972. He went to Delgado for two years, where he studied welding and got a welding certificate.

After the accident on 13 Feb 02, he continued to work at Avondale. Employer sent him to school to be a lead man because he could not use his arm. He was an acting lead man for about eight or nine months in 2003. He stopped working for Employer in May 2004. Employer took him off the ship and put him to work at light duty with the pipe fitters. However, he earned more than $17.00 per hour in his regular employment and the pipe department would not keep him at that pay. Employer then told Claimant there were no yard jobs available and let him go.

In 2004, he helped clean the church for about $300 per month and made about $2000. He dusted the pews and did other similar work, but could not do any overhead work or lifting. In May 2005, the head deacon complained that Claimant could not change the light bulbs because he could not raise his arm, so Claimant quit. Since the job at the church ended he has not done any other type of work.

He has not looked for any other type of work because his health would not allow him to. He met with Dot Moffett-Douglas for a vocational evaluation, but could not recall when. He received a report from her afterwards that listed potential jobs. He did not apply for them because he was going back and forth to the hospital.

At the present time, he has not been trying to find work. He has been in and out of the hospital because he is dealing with cancer, but intends to return to work if he can find a job he can do. He started the cancer treatments after he moved to Texas. Regardless, he still cannot do anything with his left arm. Even if there was a job he could do with his left arm, he has Bell's Palsy and cannot see out of his left eye. He could try to work if the job accommodated his left shoulder injury and his Bell's Palsy, but it is hard to find something like that. Were it not for the Bell's palsy and cancer, he could work if he did not have to use his left arm.

He does not think he could physically hold down a job because he falls asleep all the time. He has a valid Louisiana driver's license and presently owns a truck.

Claimant's Spouse testified at trial in pertinent part that:[65]

After Claimant's accident on 13 Feb 02, he complained about his arms hurting. He could not sleep on his side. After his shoulder surgery, he still was in pain. He seemed better after his cervical surgery.

Medical Evidence

Dr. Thomas Cashio's testified by deposition and his records show in pertinent part that:[66]

He has been board-certified in the field of orthopedic surgery since 1978. He first met with Claimant on 6 Jun 02. Claimant reported a history of injuring his shoulder on 13 Feb 02. Claimant slipped off a three-foot high scaffolding and grabbed to catch himself with his arms, injuring his left shoulder. He apparently re-injured his left shoulder a few minutes later when he tripped on some pipes. He indicated his left shoulder was painful. Dr. Cashio does not recall Claimant complaining about anything other than the left shoulder. If he had, Dr Cashio would have noted it in the record.

He denied any prior difficulty and apparently had seen Employer's doctor (Dr. Corcoran), who had ordered an MRI of his shoulder and then referred Claimant to Dr. Cashio. Dr. Cashio performed an orthopedic examination and found tenderness in the subacrominal area, fairly good range of motion, and pain with abduction and internal rotation. Claimant had normal reflexes sensory and motor function of his upper extremity. He reviewed some plain X-rays of Claimant's shoulder and they were unremarkable. Claimant did not have the MRI films at that time. He asked Claimant to provide the MRI films for review and told

[65] Tr. 48-52.
[66] EX-4; EX-11; CX-3.

Claimant in the meantime to return to his current level of work, which he assumed was regular duties. He knew Claimant was a welder.

He reviewed the MRI films on 10 Jun 02 and determined that Claimant had a full thickness tear of the rotator cuff as a result of his fall at work and required surgical repair. He told Claimant to continue regular activities at work until the surgery, at which time Claimant would be out for several months. Claimant did not report any other complaints.

He performed the cuff repair surgery on 18 Jun 02. It was an anterior acromioplasty, removing a portion of the acromion, which is a bone in the shoulder region. He does several such procedures every month. Generally speaking, patients are immobilized or on restricted activities for about six weeks after surgery to allow the muscles to heal. They are then given physical therapy and range of motion exercises with strengthening.

The procedure was successful and Claimant returned on 25 Jun 02. He removed the staples from the incision, left him in his arm sling, and told him to continue to stay out of work. He showed Claimant how to do rotation and elbow exercises and explained the importance of doing them. He told Claimant to avoid raising his arm, gave him a new sling and swath, refilled his analgesics and muscle relaxants, and told him to return in three weeks for a recheck. Claimant did not complain about any other part of his body that day.

He next saw Claimant on 16 Jul 02. Claimant returned without the sling and swath, which he was supposed to be using. His incision looked good and he said he had been working on his rotation exercises, but was progressing very slowly. He had some restrictions in rotation, as well as abduction. Dr. Cashio gave Claimant a shoulder pulley, showed him how to use it, and told him to work at it as hard as he could and return in two weeks. He told Claimant to continue to stay out of work. Claimant did not complain about any other part of his body at that time. Claimant was progressing very slowly and had some restriction in rotation, as well as in abduction. He had pain, but that is part of the post-operative process. Patients have to work through some pain.

He saw Claimant again on 30 Jul 02. Claimant was still quite stiff and lacked significant mobility. He recommended a course of supervised physical therapy, and told Claimant to continue to stay out of work and return in one month. Claimant did not complain about any other part of his body at that time.

Claimant returned on 27 Aug 02 and was still quite stiff. Dr. Cashio felt Claimant was developing adhesive capsulitis or some scar tissue that was restricting mobility in his shoulder. He had almost no internal and external rotation and was

only able to abduct to about 60 degrees. Dr. Cashio recommended that Claimant increase his physical therapy to five days a week and return in one month. He told Claimant he might have to consider manipulation of Claimant's shoulder under anesthesia to break loose some of the scar tissue if he did not progress. Claimant remained unable to work in any capacity. Claimant did not complain about any other part of his body at that time.

He thinks Claimant was guarding a little bit early on and did not push it as much as other people might have, thereby developing significant stiffness in his shoulder. He explained to Claimant, through the whole course of his post-operative treatment, how important it was for him to try to push it and work his shoulder.

He next saw Claimant on 24 Sep 02. His mobility had significantly improved. Claimant still had pain, but it was decreasing. He still lacked some internal and external rotation. He advised Claimant to continue the physical therapy five days a week, return in one month, and continue to stay out of work in the interim. Claimant did not complain about any other part of his body at that time.

Claimant returned again on 22 Oct 02, with a new complaint of numbness in both hands and arms, particularly when sleeping. He did not know what to make of Claimant's new complaints. It is not uncommon to have a little bit of numbness on one side after rotator cuff surgery, but it is unusual to have it in both sides. Many times, if the numbness is just at night then it is related to the patent's sleeping position. Dr. Cashio did not attribute the numbness directly to the left shoulder.

Dr. Cashio recommended a neurological evaluation and scheduled an appointment with Dr. Culicchia's group. Claimant's shoulder mobility and strength were improving and Dr. Cashio cleared him for the first time since the surgery to return to some light duty at work, with no prolonged overhead activities or any lifting over 25 pounds. Dr. Cashio thought that some work would help Claimant get his strength back and help increase his mobility. He instructed Claimant to return in three weeks for a recheck. Claimant had no other complaints.

On 1 Nov 02, Claimant went to Dr. Chris DiGrado for a second opinion. Dr. DiGrado opined that Claimant had failed to rehab following his surgery. He recommended Claimant return to therapy to regain motion and strength. He stated Claimant could return to any work below shoulder level and recommended a functional capacity evaluation (FCE).

Dr. Cashio saw Claimant next on 15 Nov 02. Claimant had some tenderness over the left deltoid muscle laterally, which Dr. Cashio attributed to post surgical pain. Claimant also had complaints of tingling in his fifth finger on the left side. He had good motor function in his hands and normal reflexes. Claimant reported his job at work changed to that of a leaderman and he felt that he could perform those activities without difficulty. Dr. Cashio told Claimant that if the finger numbness persisted he should follow up with a neurologist and then released Claimant to regular duty as a leaderman. Dr. Cashio believed that Claimant had reached maximum medical improvement as of 15 Nov 02. Although Claimant would have had some disability assignable to the shoulder, Dr. Cashio did not determine a disability rating at that time. Claimant's only complaints were regarding his left deltoid, left shoulder, and the tingling sensation he felt in his fifth finger.

Claimant returned to Dr. Cashio on 16 Dec 02, reporting that he was having trouble trying to perform his regular activities and complaining of some shoulder pain. Dr. Cashio recommended a FCE and work hardening program. Claimant still had some numbness in his shoulder and fifth finger. Dr. Cashio scheduled Claimant for an appointment with Dr. Truax's neurology group and told him to continue light duty work, but to avoid any overhead activities or any lifting over 30 pounds. Claimant was to return after the functional capacities evaluation. Dr. Cashio still believed Claimant was at maximum medical improvement. Claimant reported no other problems at that time.

Dr. Cashio did not see Claimant again until 1 Aug 03. Claimant reported injuring his right knee on 14 Jul 03, when he fell on it at work. He said Dr. Cocoran had aspirated some bloody fluid from his prepatellar bursa region about a week or two after the injury, but he had developed a recurrence of the fluid. Dr. Cashio obtained X-rays, which showed a small spur over the medial femoral condyle, but no bony injuries were noted. Claimant had some soft tissue swelling of the prepatellar bursa. Dr. Cashio re-aspirated and removed 15 cc of bloody fluid, injected the knee with cortisone, placed it in an Ace wrap, and told Claimant to do his regular activities as tolerated. Claimant reported no other problems.

Claimant next saw Dr. Cashio on 28 Jun 04, complaining of left shoulder pain and some numbness in his arm and tenderness in his shoulder. Claimant had full mobility, good rotation, and was able to abduct his arm above his head. X-rays of his shoulder were unremarkable. Dr. Cashio recommended a trial of physical therapy and told Claimant to check back with the neurologist regarding the numbness in his arm. Dr. Cashio could not determine a cause for the pain in Claimant's left shoulder and would defer to a neurologist for that. Claimant did not report any incident that would have aggravated his previous injury. They did not address any work restrictions. However, from an orthopedic prospective there were no restrictions. Claimant reported no other problems.

Claimant returned on 6 Aug 04, complaining of tenderness in the area of the previous scar, which Dr., Cashio attributed to muscle aches from therapy. Claimant did pretty well with the physical therapy that was ordered. Claimant complained of occasional numbness in his hands when he tried to work overhead, for which he was treating with a neurologist. Claimant declined an injection in the shoulder to try to alleviate any persistent pain and was placed on oral anti-inflammatory medication. Dr. Cashio told Claimant he could return to regular activities at work from an orthopedic standpoint and to follow up with a neurologist. Claimant reported no other problems. He has not seen Claimant since then.

Generally, it is more common for neck pain to radiate into the shoulder than for shoulder problems to radiate to the neck. Dr. Cashio does not remember Claimant complaining of neck pain. If Claimant had made such complaints, Dr. Cashio would have noted them in the report and tried to treat Claimant. Dr. Cashio regularly sees neck pain patients. He would defer to a neurologist as to whether neck pain first arising two years after Claimant's accident could be related to that accident.

At the time he was treating Claimant, he was not aware of Claimant's Bell's Palsy. Claimant showed up for his follow up appointments, but was not as motivated as Dr. Cashio would have liked. Once Claimant understood the importance, he responded fairly well. Dr. Cashio has no future medical plans for Claimant's shoulder other than intense physical therapy.

Dr. Colvin's 21 Apr 03 impression of mild left carpal tunnel syndrome does not really fit the distribution of the numbness Claimant reported. Carpal tunnel is usually numbness in three fingers, but Claimant's numbness was with ulnar nerve, not the median nerve and he was complaining of numbness in his fifth finger. The ulnar relates only to the fifth finger. Numbness in the ulnar is not indicative of carpal tunnel.

Sometimes the nerve that runs around the elbow can be irritated by holding it in a sling for a long time in one position. The finger numbness that Claimant was complaining about could be indicative of a cervical injury. Since the numbness did not show up until sometime after the injury, it is more likely related to the sling or something like that rather than a cervical spine injury at the time of the accident. It would most likely improve with discontinuation of the sling.

He does not think Claimant's complaints of numbness were related to the work injury.

Dr. Walter Truax's testified by deposition and his records show in pertinent part that:[67]

He has been board-certified in the field of neurology since 1979. He has certifications in the subspecialties of electromyography and clinical neurophysiology.

His first occasion to examine and treat Claimant was 8 Jun 04. Claimant was referred by Dr. Colvin, a pain management specialist who works in the same office, for some facial weakness. Dr. Colvin treated Claimant for carpal tunnel syndrome and chronic left shoulder pain. Claimant reported weakness of his face and numbness of his arm and face on the right. He was wearing splints for carpal tunnel syndrome. He related a brain injury with a skull fracture when he was seven years old, an appendectomy, and rotator cuff surgery.

Dr. Truax performed a neurological examination, which showed a right peripheral facial palsy. That meant that the seventh cranial nerve, which is the one that supplies motor sensation to the face, was not functioning correctly. It is quite typical for Bell's Palsy and explained the facial weakness. He diagnosed Claimant as having moderately severe Bell's Palsy. It is generally not clear what causes Bell's Palsy, but herpes, viral infections and Lyme disease have been identified as possible causes. It is clear to a medical certainty that Claimant's Bell's Palsy was not related to a fall on 13 Feb 02. Dr. Truax sees about 25 Bell's Palsy patients a year. Early in the process, patients are placed on a course of anti-virals. Claimant did not receive those because his condition had been present for a while. Typically Bell's Palsy would not keep people from working. Obviously, if a patient were doing something like mowing grass he might get hit in the face because the eye sometimes does not blink as well as it should. People with Bell's Palsy can communicate and use the telephone. Dr. Truax has never known patients to have problems with their ability to drive as a result of their Bell's Palsy syndrome. However, they might have to get used to wearing an eye patch. Claimant's employability did not come up in their discussions. Bell's Palsy typically does not affect vision, except sometimes the patient cannot close his eye and the cornea could dry out resulting in keratitis. He does not recall Claimant reporting any vision problems.

He also tried to ascertain the cause of Claimant's right arm numbness. He sent Claimant for an MRI scan and did a carotid ultrasound.

[67] EX-5; EX-12.

On 18 Jun 04, Claimant returned to review his tests, which were normal. He reported seeing an ophthalmologist and apparently has some exposure keratitis. Most Bell's Palsy patients get better within weeks or several months. Some people take a lot longer and some do not ever recover completely. If there is severe nerve damage, it can take up to six months or longer to reach maximum improvement. Since Claimant could not close his eye normally, he probably could not work in a place where he could get hit in the face with something. Had the jobs at pages 7 and 8 of the 8 Dec 05 vocational rehabilitation report[68] been available as of 18 Jun 04, Claimant could have done them from a neurological perspective. He had not reached maximum medical improvement at that time as to his Bell's Palsy.

Dr. Truax next saw Claimant on 30 Aug 04. He was referred by Dr. Barrett, a neurologist on staff at LSU. Claimant had seen Dr. Barratt on the advice of his attorney. She knew that he had seen Claimant before and was concerned that Claimant might have some kind of systemic problem like amyotrophic lateral sclerosis. Claimant was having numbness of his hands and carpal tunnel syndrome would explain that. Claimant still complained of pain in his shoulders. Dr. Truax re-examined Claimant, who still had right facial palsy. Claimant gave way on muscle testing on the left side and had some subjective diminished sensation on the right side of his body and the left side of his face.

Claimant had give-way on muscle testing, which is usually associated with somebody trying to feign weakness. Claimant also said he was numb on the right side of the body, which really did not make any sense. He had just done the MRI scan several months before and there did not appear to be any reason for that from a neurological perspective. Except for that one incident, Claimant seemed credible and cooperative.

Carpal tunnel syndrome is the compression of the median nerve at the wrist. It was bilateral with Claimant. Dr. Truax probably sees seven or eight people a week with carpal tunnel syndrome. It was his impression, on 30 Aug 04, that Claimant's hand numbness was more likely than not related to carpal tunnel syndrome. He did not communicate his findings to Dr. Barrett. He did not discuss Claimant's ability to work with Claimant, but as of that date, Claimant could have still done the jobs listed in the December 2005 report.

Dr. Truax saw Claimant for the last time on 29 Nov 04. Claimant said he was having twitching around his eye on the left and his Bell's Palsy was much better.

[68] EX-2.

Claimant had some mild to minimal facial weakness in his upper face and minimal weakness in his lower face, but was much improved.

Dr. Truax does not believe the palsy is related to Claimant's injury at work in February 2002. If Claimant had complained of neck pain, Dr. Truax would have noted it in the records. He does not recall Claimant having any complaints about neck pain.

Dr. Deepak Awasthi's testified by deposition and his records show in pertinent part that:[69]

He has been board certified in the field of neurosurgery since November 1996.

He initially saw Claimant on 13 Jan 05 on a referral from Dr. Diana Barratt. She was concerned about his evolving weakness on the left side and felt that Claimant exhibited signs of spinal cord compression. Claimant stated that he had neck stiffness with occasional neck pain and left sided weakness as his main complaints. He stated he was doing well until he had a fall at work on 13 Feb 02 that led to a rotator cuff injury, which required surgery. He continued to go to physical therapy without any relief of his left upper extremity stiffness and pain in the shoulder region. Claimant felt that his arm was more comfortable in the flexed position and described weakness on the left side. He stated his left leg would give out and he had tingling in both hands. Dr. Awasthi performed a neurosurgical examination of Claimant, which disclosed a decreased range of motion of the neck, weakness of his grip on the left side, and weakness over the triceps on the right side. While those are largely subjective, Claimant also had a positive Romberg sign, which cannot be faked. It is an early sign of spinal cord compression. Claimant's reflexes were also overall increased, which is another early sign of spinal cord compression.

Claimant brought a previous MRI that showed significant spondylitic disease, which is wear and tear changes, most prominently at the C5-6 level, where there was a bone spur, which was impinging upon the spinal sac in the spinal cord at that level. Claimant also had changes at C4-5 of bone spurs as well, more prominent on the left side. Those were all degenerative findings associated with wear and tear. They are not unusual for patients of Claimant's age. His impression was that Claimant had early signs of spinal cord compression and he strongly suggested that Claimant consider an anterior cervical discectomy and fusion surgery to prevent further deterioration of the functioning of the spinal cord and prevent any further damage to the spinal cord.

[69] EX-6; EX-13; CX-1.

Claimant's spinal cord compression symptoms were due to the spondylosis, but, after a fall, the bone spur can hit the spinal cord and the patient can get spinal cord compression symptoms, with weakness, tingling in the hands, and weakness of the hands. Those can remain for a long period of time, depending on how much of a spinal cord compression still persists and how much the spinal cord has recovered from the initial injury. From that perspective, Claimant had underlying spondylosis, which given his history and the fact that he denies any other significant accidents, allowed the fall to precipitate the spinal cord symptoms and signs.

The findings on the MRI scan may well have pre-existed Claimant's 2002 accident because they were findings of degenerative changes. The fall of February 2002 aggravated the pre-existing spondylosis, based upon Claimant's history.

A patient who has spondylosis that subsequently results in myelopathy can present without neck pain. They can simply have tingling, weakness, walking difficulties or weakness of the lower or upper extremities, without any neck pain. That can happen in a patient who has a spinal cord injury occurring after a fall and the bone spurs are hitting the spine.

He recommended surgery for Claimant. Based upon the history given by Claimant, Dr. Awasthi's review of the MRI scan and his neurosurgical examination, it is probable that his recommendation for surgery was related to the fall in February 2002.

He saw Claimant again on 17 Feb 05 for a pre-operative evaluation. Claimant's condition had not changed. He still had weakness in his hand grip and a positive Hoffman's sign. Claimant had his surgery on 25 Feb 05. The surgical procedure was done at 4-5 and 5-6 and went without any difficulties. Claimant's post-operative course was uneventful, without any complications.

On 27 Jun 05, Claimant returned with some weakness in his neck area and was not able to keep his neck up. He complained of occasional stiffness and soreness in his neck. His left hand weakness had improved and he no longer had a positive Hoffman sign. Claimant's X-rays looked like the fusion was progressing appropriately at the two levels. The plate was in satisfactory position, but the bottom screws did not appear to be in the ideal position. He told Claimant that he might want to consider physical therapy to strengthen his neck. Although Claimant was set to return to the clinic, the hurricane in New Orleans intervened and 27 Jun 05 was the last time he saw Claimant.

Claimant had not yet reached maximum medical improvement regarding his cervical spine. Claimant was still only about four months post-surgery and it usually takes six months to one year before one wants to re-check the fusion.

As of 27 Jun 05, Claimant could probably not work because he still had weakness in his neck, which may have required some physical therapy. In the long run, it would be quite possible that Claimant would have improved with time. But for Hurricane Katrina, had Claimant returned in three months and his progress remained consistent, he would have been able to perform some sort of light activity and would have been at maximum medical improvement around September 2005. Claimant would have needed to avoid lifting, pushing, pulling above 20 or 30 pounds, positions where he constantly had his neck in a hyper extended position or arms above the shoulder level, crouching positions, and climbing ladders.

In a given year, Dr. Awasthi would see about ten to twenty patients with spondylosis with myelopathy. It would be unusual for the myelopathy to not manifest itself until over two years after the aggravating trauma. It would be unusual that the spondylosis visible on the MRI scan, on its own natural progression, reached such a point that it caused the myelopathy and Claimant's complaints in the absence of any traumatic event. Usually spondylosis, as it progresses, causes neck pain or radicular symptoms, rather than spinal cord symptoms. Spinal cord symptoms usually involve some kind of an inciting traumatic event. The natural history of cervical spondylosis is typical of neck pain, arm pain, or tingling going down the arms or hands. The traumatic event may be something benign such as a sneeze, but more often than not, it is typically a fall where the neck goes into a hyper extended position. The absence of a complaint about neck pain does not change his opinion because somebody can have cervical cord findings without any pain.

If Dr. Colvin wrote a letter in January 2005, stating that based upon her treatment of Claimant from a pain management perspective, she did not believe that the cervical myelopathy was in any way related to the work related accident of 2002, he would defer to Dr. Colvin.

Claimant was a cooperative patient and he had no reason to doubt Claimant's complaints of pain.

Consistent complaints of arm pain and numbness from approximately five months after the February 2002 fall, up to and after the time that Claimant was treated by Dr. Barratt would tend to support a conclusion that the neck injury was related to the February 2002 fall. Complaints of arm pain or the radicular complaints can be indicative of a cervical injury.

If Claimant has done well from the surgery and his fusion is good, his main restrictions would be to avoid pushing, pulling or lifting anything more than about 40 or 50 pounds, raising his arm above his shoulder level or his neck in a hyper extended position, and crouching. Wearing a welding hood would depend on the weight of the hood.

Dr. Meda Colvin's testified by deposition and her records show in pertinent part that:[70]

She has been a medical doctor for about 20 years and is board-certified in physical medicine rehabilitation.

She first met Claimant on 27 Feb 03. He was referred to her by Dr. Thomas Cashio for an evaluation from the pain management perspective. Claimant had a rotator cuff repair done by Dr. Cashio. Claimant described a fall at work and treatment with a sling, but he continued to have shoulder pain. An MRI was done followed by a torn rotator cuff repair, in June 2002. He started physical therapy after surgery, but continued to have pain, numbness and tingling in his left arm, forearm and hand. He noted increased pain when he lies on it in a certain position.

She performed a physical exam and found Claimant had adequate active range of motion with some tenderness of his left deltoid. That is where the rotator cuff attaches. His Spurling sign, which is an indication of cervical radiculopathy, was negative. Claimant had decreased sensation distribution of the radial nerve of his hand. His reflex was equal and muscle strength was good. Although the Spurling test is not totally diagnostic, if Claimant had some sort of spinal cord compression at the cervical spine level, the test would have been suggestive.

She recommended an EMG for the cervical spine to see if there was any nerve damage from a radicular pain or if it was a brachial or nerve injury. She diagnosed Claimant with possible radial nerve neuropathy or brachial plexopathy. She does not recall any complaints of neck pain and did not note any in his chart. On his pain chart drawing, Claimant only indicated pain in his arm and shoulder.

An EMG was performed on 14 Apr 03. Claimant returned to Dr. Colvin on 21 Apr 03, after the EMG and nerve conduction tests. Those tests resulted in a very minimally abnormal study for mild median nerve entrapment across the left wrist, which was significant for very mild carpal tunnel syndrome. If Claimant had a cervical myelopathy or if there was any other abnormality with the cervical spine, such as a cervical radiculopathy, the EMG test normally would have detected it. Claimant's complaints of tingling and numbness in his left arm could be attributed

[70] EX-7 (where cited, see fn. 3, supra.); EX-14; CX-5.

to his carpal tunnel syndrome. Claimant reported some episodes of dizziness, but that could have been a side effect of his medication. Claimant did not mention neck pain and once again noted wrist and shoulder pain on his pain chart. Dr. Colvin prescribed Extra-Strength Tylenol and Bextra, along with occupational therapy for his carpal tunnel syndrome on the left.

Claimant returned on 21 May 03, with continued pain in his left shoulder. She assessed that Claimant suffered from mild carpal tunnel confirmed by the EMG. She recommended occupational therapy and continued medication.

When she saw him next on 20 Jun 03, he reported feeling much better, but having some symptoms on the left and right. He achieved some numbness relief with positioning and stretching. Claimant still had a positive Tinel sign for carpal tunnel syndrome, but his numbness went away. She believed Claimant was at maximum medical improvement. She prescribed splints for both arms for the carpal tunnel syndrome and told Claimant to follow up in 3 months.

On 18 Sep 03, Claimant returned and reported doing very well. He still had some left arm and hand pain, but had full range of motion of his left shoulder. Her exam revealed tenderness in his left biceps to grip strength. Claimant's pain drawing showed pain in the left shoulder and left arm. She assessed Claimant as being post rotator cuff surgery and having carpal tunnel syndrome that was improving with therapy. She advised Claimant to continue his home program, use Lidoderm patches on his arms, and continue taking Bextra.

When Claimant returned on 12 Dec 03, he still had left shoulder and arm pain, that worsened in cold weather. He was not wearing his splints correctly. He had them on backwards. The physical exam showed a functional range of motion, with some pain. Claimant's pain drawing showed pain in his left forearm and shoulder. She had no restrictions on Claimant's ability to work beyond what Dr. Cashio already imposed.

She saw Claimant again on 26 Jan 04. He complained of left shoulder pain, particularly when it was cold. The physical exam disclosed tenderness in his left shoulder and adequate range of motion. He did not indicate any areas on his pain drawing. She did not recall Claimant complaining of any neck pain and has no notes in his charts showing he did. She saw no reason Claimant should not return to some type of work as of 26 Jan 04. She believed Claimant's carpal tunnel syndrome was minimal and did not require a release.

Claimant returned on 8 Jun 04 complaining of facial weakness and numbness in his face and right arm, along with chronic pain in his left shoulder. She referred him to Dr. Truax because she was concerned that Claimant may have had a stroke.

On 9 Jun 04, she limited Claimant to light duty with no welding and a possible return to work on 14 Jun 04. Claimant needed a note for work, and she did not want Claimant to do anything until a stroke was ruled out.

She saw Claimant again on 18 Jun 04. An MRI did not show any stroke and Claimant was now complaining of severe pain in his left shoulder. He said he could not move it. She referred Claimant back to Dr. Cashio and noted work restrictions of no overhead activity, no lifting above 10 pounds, and no welding.

Claimant returned on 20 Jul 04 after seeing Dr. Cashio. Claimant was doing some sedentary jobs with no overhead activity, no welding, and no lifting more than 20 pounds.

She saw Claimant again on 31 Aug 04. He still had left shoulder pain. Claimant also reported pain on the left side of his neck for first time. The physical exam showed decreased range of motion and high shoulder pain at external rotation, along with facial weakness from Bell's Palsy. Claimant was still on temporary restrictions of no welding, no overhead activity, and no lifting greater than 10 pounds until an FCE was performed.

Even though she would defer to the results of the September 2004 FCE report, the report corroborated her findings. Claimant was performing light/medium work duty and occasionally lifting 35 maximum lifting. He gave full effort. He demonstrated decreased range of motion and strength in his left upper extremity, decreased bilateral hand strength, and was guarding. The FCE recommended a two-to-four week work hardening program, with emphasis on upper extremity strengthening to attempt to improve functional performance.

Claimant returned on 3 Jan 05 after he had retained an attorney. He was seeing Dr. Awasthi and Dr. Barratt, but she had not referred him to either. His pain drawing indicated pain in his left shoulder and left arm. She was unclear as to why he came back to see her since he was treating with other doctors who were providing work restrictions for him.

She never saw any evidence of cervical myelopathy at multiple levels with radiculopathy over the course of her treatment of Claimant. To opine about that, she would need, among other things, an MRI of the cervical spine. She never ordered an MRI of the cervical spine because there was no indication on the EMG and his pain complaints had been mostly in his shoulder and his hand. A cervical myelopathy is often bilateral. Patients with cervical myelopathy often cannot walk

and are incontinent. Claimant never related any complaints consistent with cervical myelopathy. Claimant was cooperative, open, and talked a lot. She did not find any instances where his subjective complaints were out of line with her findings.

An MRI showing bilateral neuroforaminal stenosis at the C3-4, C4-5, C5-6, and C5-7 levels would be common for patients at a certain age. As people age, their discs degenerate and there is less space between them. It is a degenerative arthritic response. As they age, everybody has foraminal stenosis at some level.

A finding of a diffused bulge of the annulus fibrosis, with marginal osteophyte formation at each of the above levels and also a C5-6 posterior osteophytic bar pressing upon and deforming the ventral surface of the spinal cord are likewise arthritic changes that can be part of the natural aging process.

Those types of findings on a November 2004 MRI of Claimant's cervical spine, would not be suggestive of an accident happening in February 2002, but rather are arthritic changes not related to an accident.

Had the jobs identified in the 8 Dec 05 vocational rehabilitation report[71] been available as 3 Jan 05, she believes they would have been appropriate for Claimant from a pain management and a physical medicine and rehabilitation perspective.

She has not had a chance to review Dr. Cashio's medical records and was not aware that Dr. Cashio requested a neurological evaluation for numbness in his fifth finger. Numbness in the fifth finger is not indicative of carpal tunnel.

She treated Claimant for about two years. Claimant never reported any accidents other than the 13 Feb 02 accident. He consistently complained of pain in his left shoulder, arm, and forearms, mainly his upper arm and his shoulder. On a few occasions, he complained of numbness and tingling in his hands and fingers. She never considered that Claimant had possibly suffered a neck injury.

Cervical myelopathy, with spondylosis, can be caused by a traumatic fall. Shoulder pain or weakness can be a symptom of cervical myelopathy, but would not be the only symptom. Numbness in the arm and tingling in the fingers are normally not symptoms of cervical myelopathy, but could be part of a whole

[71] EX-2.

symptomatology. The patient needs to have other symptoms to make Dr. Colvin think that it is a myelopathy. A positive Romberg is not necessarily a symptom of cervical myelopathy. Patients can have cervical myelopathy or spinal cord compression without any neck pain, but she does not know how common that would be.

She never ordered a cervical MRI of Claimant. As a physical medicine rehabilitation doctor she works in neurology, but for something very technical, like a myelopathy, she would defer to a neurosurgeon. If she sees symptomatology of cervical myelopathy, which normally includes problems with walking, incontinence and not having normal range of motion of both arms, she sends them to a neurosurgeon because the remedy for a cervical myelopathy is usually a decompression.

Based on the results of the November 2004 MRI, if Claimant had aggravated those conditions as a result of a fall at work in February 2002, she would have expected Claimant to have complained about neck pain very soon after his accident. He would have reported neck pain soon after the aggravation occurred. The first time Claimant related any sort of neck pain whatsoever was on 31 Aug 04.

Dr. Diana Barratt's records show in pertinent part that :[72]

On or about 25 Aug 04, Claimant was referred to Dr. Barratt by his attorneys. He reported the fall in 2002, his resulting shoulder injury, and subsequent treatment. She questioned if Claimant had a possible C-spine injury and ordered an MRI. On 26 Aug 04, she discussed Claimant's case with his attorneys. They indicated they would send her his records and schedule a C-spine MRI for him.

On 1 Nov 04, an MRI showed bilateral neural foraminal stenosis at C3-4, C4-5, C5-6, and C6-7. It showed posterior osteophytic bar pressing upon and deforming the ventral surface of the cervical spinal cord. Claimant returned to her clinic on 9 Nov 04 and continued to complain of shoulder and neck pain. He reported having trouble sleeping because of the pain. She ordered an EMG to assess Claimant's nerve root involvement with the stenosis at C3 to C7 and to assess Claimant's need for treatment of carpal tunnel syndrome.

She spoke to both Dr. Cashio and Dr. Truax about Claimant, since they had also treated him. Dr. Cashio said his care of Claimant was limited to the shoulder and Dr. Truax indicated he had only treated Claimant's Bell's Palsy.

[72] CX-2.

A 23 Nov 04 EMG showed cervical radiculopathies at C5 to C8. Based on the EMG, she determined Claimant did not suffer from significant carpal tunnel syndrome and all of his symptoms were originating from his back. She referred Claimant to Dr. Awasthi.

Department of Labor Forms show in pertinent part that:[73]

Employer paid Claimant temporary total disability compensation based on an AWW of $591.20 from 14 Jun 02 to 22 Oct 02, and from 10 Aug 04 to 23 Dec 05.

Claimant's personnel records show in pertinent part that:[74]

Claimant started working for Employer as a welder in 1977. His last day of work was 9 Aug 2004. His accident in February 2002 resulted in a Type III impingement of his left shoulder.

Employer's medical records show in pertinent part that:[75]

Claimant sustained a left shoulder injury on 13 Feb 02 and was treated by Employer's medical staff with ice and ibuprofen. Claimant returned to the clinic the next day complaining of shoulder pain and was sent for an x-ray. The x-ray showed no fractures. He was told not to use his left shoulder.

On 21 Feb 03, he returned to the clinic, reporting improvement. He was returned to regular work as tolerated. On 4 Mar 03, Claimant came to the clinic requesting Motrin. On 25 Mar 03, he reported his shoulder tightening up overnight. He reported no point tenderness and otherwise had full range of motion. He was continued on full duty and given ibuprofen. On 2 Apr 02, he reported continued soreness, was given an injection in his deltoid, and was continued on full duty. On 9 Apr 02, he reported felling much better. He requested and received an additional injection. He continued on full duty. On 19 Apr 02, Claimant reported doing better, but he still suffered from morning stiffness. He received a medrol dose pack, but stayed on full duty. On 30 Apr 02, Claimant reported the dose pack worked well and he was feeling better, with full range of motion.

On 28 May 02 he returned with complaints of shoulder pain. He was scheduled for an MRI, but was continued on full duty. The MRI revealed a Type III impingement. Claimant stayed on full duty, but was sent for an orthopedic consult.

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[73] EX-1.
[74] EX-3.
[75] EX-8.

On 23 Oct 02, Claimant was limited for three weeks to lifting no more than 25 pounds and no climbing ladders. On 12 Dec 02, he was limited for ten (10) days to lifting no more than 30 pounds and no working overhead. On 7 Jun 04, Claimant was limited for two days to lifting no more than 25 pounds. On 14 Jun 04, Claimant was limited for four days to lifting no more than 25 pounds and no welding. On 21 Jun 04, Claimant was limited for one month days to lifting no more than 10 pounds, no working overhead, and no welding. Those limits continued through 10 Aug 04, when Claimant was limited to lifting no more than 10 pounds and no working overhead, but Employer had no work within those limits. Employer also had no work within Claimant's limits on 14 Mar 05, 31 Mar 05, and 27 Jun 05. During that time, he was limited to lifting no more than 10-20 pounds, no overhead work, and no prolonged standing or sitting.

Claimant's physical therapy records show in pertinent part that:[76]

Claimant started physical therapy on 30 Jan 03. He complained of numbness in his lower left arm and reported he was unable to work overhead, do heavy lifting, pull, or reach behind his back. He said he was working as a leaderman and did not intend to go back to welding. He had about 14 therapy sessions over the next month and on discharge reported that his shoulder was doing much better, that he could tolerate pulling leads at work better, and he was training to be a supervisor so he would not have to weld.

He returned to physical therapy on 9 Jun 03, complaining of being unable to work for more than an hour. He reported numbness in his left hand depending on his position, occasional numbness in his right hand and weather related left shoulder pain from arthritis. He stated his job as a leaderman involved no physical stresses and was mostly sedentary. He had five therapy sessions over the next two to three weeks. At discharge on 18 Jun 03, he reported he was going to see Dr. Colvin to see what she thought, but was otherwise vague about his symptoms. Claimant had a decrease in strength over the course of treatment and made inconsistent and vague statements. Claimant stated he was going to start welding again; that Employer wanted him to work on Sundays, which was against his religion; and that he was staying on light duty.

[76] EX-9.

Vocational Rehabilitation Evidence

Michael Nebe's testimony at trial and records show in pertinent part that:[77]

He has been a licensed vocational rehabilitation counselor since 1993. He reviewed an updated report by Dot Moffett-Douglas from 8 Dec 05.[78] The report included a Transferable Skills Analysis, which looked at the jobs that Claimant performed in his work history to determine if those skills would transfer to other jobs within his medical restrictions. Mr. Nebe believes the report meets and comports with the standards of vocational rehabilitation counseling for the State of Louisiana, as he understand them in his capacity as an expert in that field. The report identified jobs that comported with Claimant's educational background, work history, and medical status. They were within the sedentary duty category, requiring some walking, but generally required sitting and no lifting over ten pounds.

As of August 2005, the following jobs were available in New Orleans:

Parking lot cashier - $6.50 per hour
Aquarium cashier - $6.25 per hour
Airport parking lot cashier - $6.75 per hour

He has also reviewed another report that indicated potential employers were contacted in December 2005.[79] As of December 2005, the following jobs were available in Houston:

Cashier - $7.00 per hour
Toll booth attendant - $8.50 per hour
Gate attendant/driver - $9.20 per hour
Loss prevention associate - $8.00 per hour
Security firm guard - $7-9 per hour
Security firm guard - $8-10 per hour
Parking lot cashier - $6-7 per hour
Target security guard - $7.50-8.50 per hour
Wal-mart loss prevention - $8.50-9.00 per hour
Parking lot security guard - $7.50-8.50 per hour
Kohl's security guard - $8.50-9.00 per hour
Security firm guard - $8.50-12.00 per hour
Telephone surveyor - $8.00 per hour

[77] Tr. 53-78; EX-2.
[78] EX-2, pp. 1-8.
[79] EX-2, pp. 9-14.

The report did not state that Claimant had cervical surgery, suffers from 85 percent hearing loss in his left ear, or has Bell's Palsy. It listed thirteen different employment positions that were contacted only on 15 Dec 05, and does not state how long those positions were available. Mr. Nebe took into account Claimant's Bell's Palsy, cervical surgery and left shoulder injury, when considering whether those jobs were appropriate. Most of the jobs listed appeared to generally comport with the standards of vocational rehabilitation. There were a few jobs that Mr. Nebe might have attained more information about, but he had no question about the appropriateness of a number of the jobs, including cashier, prevention associate, parking lot security, telephone survey, and tollbooth attendant positions.

He had reservations about the driver position because it did not indicate whether the driver would have to move or unload things. The prevention associate position looked appropriate as it primarily involves surveillance work and recording information. He was not comfortable about the security position because it did not indicate if there would be any type of apprehension requirements. The loss prevention positions at Wal-Mart normally require apprehending people and would not be appropriate. The parking lot security employer usually hires older people and allows them to call police if they have to deal with anyone. He is comfortable with Claimant performing sedentary work that comports with Claimant's work history, his educational background and his medical status.

In addition to reviewing those reports, he also prepared two of his own reports. The first one, dated 12 Jun 06, reviewed Ms. Moffett's evaluation and labor market survey, with an updated labor market survey, to determine if there were jobs that were available and appropriate for Claimant at that time.[80] He identified five positions in and around the metro New Orleans area. He personally contacted the employers to ensure that the jobs referenced were available at the time stated in the report. The jobs were all within the sedentary to light duty category, but were mainly sedentary and paid between $6.00 and $8.92 an hour, full time. The jobs took into consideration Claimant's educational background and his work history, as well as his medical reports and status. The following jobs were available between June/July and December 2005:

New Orleans hotel parking booth attendant paying $8.00 per hour
New Orleans hotel shuttle driver paying $7.00+ per hour
New Orleans convention badge checker paying $8.00 per hour
Metairie bridge safety monitor paying $8.92 per hour
New Orleans hotel booth attendant paying $8.00 per hour

[80] EX-2, pp. 15-20.

The report also identified a job at the Kenner airport as technical support, which only took into account Claimant's longshore-related limitations. It paid $9.50 per hour.

Mr. Nebe never interviewed Claimant. In his 12 Jun 06 report he noted that Ms. Moffett-Douglas reported that Claimant developed Bell's Palsy following surgery. He is not aware that Claimant developed Bell's Palsy prior to his cervical surgery. When he wrote the report he knew Claimant had resided in Pearland, Texas since Hurricane Katrina.

ANALYSIS

Longshore Work Nexus of Neck Injury

The critical issue in this case is whether Claimant's cervical condition was either a result of his fall on 13 Feb 02 or a pre-existing condition aggravated by that fall.

Claimant's testimony on this point is essentially that he had left arm pain and numbness after the fall and continuing through his shoulder surgery and rehabilitation. He says it improved after his neck surgery. Claimant's spouse likewise testified that he improved after the neck surgery.

Dr. Cashio treated Claimant's shoulder and performed the rotator cuff surgery. He treated Claimant from 6 Jun 02 to 6 Aug 04. He does not recall Claimant ever complaining about neck pain. He could not determine a source of the pain in Claimant's left shoulder and deferred to a neurologist as to the source and as to whether the original accident could account for Claimant's neck pain first felt two years later. He does not believe a diagnosis of carpal tunnel syndrome explained Claimant's reports of hand numbness. He thinks the numbness is more likely related to Claimant wearing the sling, rather than a cervical spine injury from the original fall. He would not relate the numbness to the fall.

Dr. Truax treated Claimant for Bell's Palsy from 8 Jun 04 to 29 Nov 04. Claimant reported left shoulder pain and some numbness in his right arm and face. He is certain that there is no relationship between the Bell's Palsy and Claimant's fall. When Dr. Barratt sent Claimant back for further evaluation, Dr. Truax noted some indication that Claimant was feigning weakness, although Claimant otherwise appeared credible. Claimant also reported right side body numbness, which did not match any objective findings. He believed Claimant suffered from bilateral carpal tunnel syndrome, which would explain his complaints of hand numbness. He recalls no complaints of neck pain by Claimant.

Dr. Colvin treated Claimant from 27 Feb 03 to 3 Jan 05 for pain management. Claimant complained primarily of left shoulder and arm pain. On a few occasions he complained of numbness in his hands. He never mentioned neck pain until August 2004. Dr. Colvin has seen nothing to lead her to suspect cervical myelopathy at multiple levels. Claimant had no complaints consistent with cervical myelopathy. She opined that while shoulder pain or weakness can be a symptom of cervical myelopathy, they would not be the only symptoms. She testified that numbness in the arm and tingling in the fingers are normally not symptoms of cervical myelopathy, although they could be part of a whole symptomatology. A patient would have to have other symptoms to make her think that it is myelopathy. A positive Romberg is not necessarily a symptom of cervical myelopathy. On his first visit, Claimant had a negative Spurling test, which although not totally diagnostic, would have been suggestive of spinal cord compression at the cervical spine level. In the absence of any other signs, she would need to see a MRI to make such a determination in Claimant's case.

Dr. Colvin opined that bilateral neuroforaminal stenosis at the C3-4, C4-5, C5-6, and C5-7 levels are a common consequence of aging and a degenerative arthritic response. Everybody has foraminal stenosis at some level. She added that a diffused bulge of the annulus fibrosis with marginal osteophyte formation at each of those levels and also a C5-6 posterior osteophytic bar pressing upon and deforming the ventral surface of the spinal cord are also arthritic changes that can be part of the natural aging process.

Based on the November 2004 MRI, if Claimant had aggravated his cervical spine as a result of a fall in February 2002, Dr. Colvin would have expected Claimant to have experienced neck pain very soon after the fall, and he did not.

Dr. Awasthi treated Claimant from 13 Jan 05 through 27 Jun 05 and performed Claimant's back surgery. Claimant complained of neck stiffness with occasional neck pain and left sided weakness. Claimant had a positive Romberg sign and increased reflexes, which are early signs of spinal cord compression. Claimant's previous MRI showed significant spondylitic disease, which is wear and tear, along with other degenerative findings. Dr. Awasthi opined that degenerative changes are not unusual for patients of Claimant's age. He believes that the findings on the MRI scan may well have pre-existed Claimant's 2002 accident because they were findings of degenerative changes. Based on Claimant's history, Dr. Awasthi thinks that the fall of February 2002 aggravated his pre-existing spondylosis and the surgery he performed was related to that fall.

Dr. Awasthi further testified that a patient who has spondylosis that subsequently results in myelopathy can present without neck pain, but that it would also be unusual for the myelopathy to not manifest itself until over two years after the aggravating trauma. On the other hand, he observed that it would be unusual that the spondylosis on its own

natural progression reached such a point that it caused the myelopathy and Claimant's complaints in the absence of any traumatic event. However, he indicated that if Dr. Colvin opined in January 2005 that the cervical myelopathy was not in any way related to the work related accident of 2002, he would defer to Dr. Colvin.

Since Dr. Barratt never testified or subjected herself to cross-examination, it is difficult to effectively evaluate her opinion, particularly as it might relate to the question of the source of Claimant's neck problems. Her records indicate that based on an EMG, she did not believe Claimant had carpal tunnel syndrome and felt that all of his problems were originating from his back.

The record is clear that Claimant suffers from cervical back problems. Dr. Awasthi's testimony is evidence that those problems could be the consequence of Claimant's fall at work. On the other hand, Dr. Colvin, Dr. Truax, and Dr. Cashio's testimony concerning age related degeneration and carpal tunnel syndrome is sufficient to rebut that presumption. As a result, the burden of proof as to the nexus between the fall and the neck problems rests on Claimant. While Dr. Awasthi opined favorably for Claimant in that regard, he was equivocal to some extent in conceding that he would defer to Dr. Colvin. On the other hand Dr. Colvin and Dr. Cashio were Claimant's treating physicians for an extended period. Although Dr. Colvin did not see the MRI Dr. Barratt relied on, she had a chance to address it in her testimony.

The weight of the totality of the evidence in the record is insufficient to establish that Claimant's back problems are more likely than not related to his fall. Thus, any claims for medical care or compensation related to his back injury must be denied.

Nature and Extent of Shoulder Injury

Claimant injured his shoulder on 13 Feb 02. The weight of the record establishes that he was never able to fully return to his original job as a welder. Consequently, he is presumed totally disabled as of that date and continuing, in the absence of evidence of suitable alternative employment. However, the record also establishes that with some intermittent absences,[81] Claimant was able to return to work for Employer as a lead man. That was sufficient to establish SAE for that time. Moreover, his pay did not diminish and he suffered no loss of earning capacity while he worked for Employer. Eventually, however, Employer told him it could not afford to pay him at his higher wage and let him go. Employer's records indicate he stopped working on 9 Aug 04. Consequently, Employer must establish SAE from that time on.

[81] Including a period of stipulated total disability from 14 Jun 02 to 22 Oct 02.

The parties stipulated that Claimant was properly compensated total disability from 10 Aug 04 to 24 Oct 04 and, after an anomalous one day interval, from 26 Oct 04 to 13 Feb 05. They also stipulate that Claimant was properly compensated for his partial disability from 29 Apr 05 to 24 Dec 05. At issue, is Claimant's entitlement to disability from 13 Feb 05 to 29 Apr 05 and from 24 Dec 05, to present and continuing.

13 Feb 05 to 29 Apr 05

Claimant's counsel argued pre-trial and in his brief that Claimant did not receive any disability benefits during his cervical surgery and recovery. However, neither Claimant nor his spouse mentioned that in their testimony. Employer concedes that Claimant was totally disabled during that period, but that it paid Claimant full benefits. In support of that position it offered an LS-208 that shows payment of total benefits from 10 Aug 04 to 23 Dec 05. Based on the evidence in the record, I find that it is more likely than not that Employer paid total disability benefits to Claimant for the disputed period.

24 Dec 05 to present and continuing

In establishing SAE, Employer must show jobs which account for what Claimant can physically and mentally do post-injury. However, Employer is not a guarantor of employment and if unrelated intervening events impacted Claimant's employability, Employer need not show jobs that account for those limitations. In this case, Claimant's neck problems, Bell's Palsy, and cancer are all independent events, for which Employer is not obliged to account in identifying SAE. That leaves only Claimant's shoulder problem as the primary post-injury physical limitation that SAE must take into account.

Dr. Cashio treated Claimant's shoulder. He found Claimant to be at MMI as to his shoulder as of Claimant's 15 Nov 03 appointment. He released Claimant to regular duty as a leaderman, but understood from Claimant's reports that the job was supervisory and within Claimant's capabilities. When Claimant returned one month later reporting trouble while trying to perform his regular activities, Dr. Cashio still believed Claimant was at maximum medical improvement. Dr. Cashio released him to return to his regular job, but restricted him from any overhead activities or any lifting over 30 pounds. I find those to be the limitations that Claimant suffered as a result of his Longshore related injury and the constraining facts on SAE.

The vocational experts who generated the list of jobs offered by Employer stated that they took not just Claimant's shoulder problems, but all of his current physical limitations into account. They included jobs in the New Orleans area, where Claimant resided at the time of his injury, and Houston, where Claimant lived from September 2005 until two weeks before the hearing, when he moved to Pearland, which is a suburb

of Houston.[82] The weight of the record demonstrates that, excluding the listed Houston jobs which the testifying expert questioned, there were still a sufficient number of positions generally available to establish SAE.[83] These were clearly jobs that were consistent with Claimant's age, background, education and training and did not require him to exceed the limitations related to his shoulder injury. Claimant could reasonably be expected to do them. They were reasonably available in his community and he reasonably could be expected to secure them.

Taking an average of the lowest end of the hourly wage for each listed job yields a post injury hourly earning capacity of $7.41 and a weekly earning capacity of $296.40.

ORDER AND DECISION

1. Claimant injured his shoulder in the course and scope of his employment under the Act on 13 Feb 02.

2. Claimant's cervical spine injuries are neither a consequence of, nor were aggravated by, his work related accident.

3. The claim for medical care related to treatment for Claimant's cervical spine problems is denied.

4. Claimant reached maximum medical improvement as to his shoulder on 15 Nov 02.[84]

5. Claimant has been at least partially disabled due to his shoulder since 13 Feb 02, with periods of suitable alternative employment provided for by Employer and periods of total disability.

6. During the time that Claimant worked in suitable alternative employment for Employer, he suffered no loss of earning capacity.

7. Claimant's average weekly wage at the time of his work-related injury was $591.20.

[82] The Court takes judicial notice that the distance from Pearland to Houston is 17 miles.
[83] CX-2, pp. 9-13 (jobs 1, 2, 7, 8, 10, 13).
[84] This finding is contrary to the parties' stipulation that Claimant was temporarily disabled through various periods after 15 Nov 02. However, MMI was never a central subject of the litigation and the parties seemed to have focused on MMI as to the cervical problems, rather than to the shoulder. I base my finding as to the shoulder MMI on the testimony of the orthopedist that treated his shoulder.

8. Employer provide all appropriate and due compensation benefits for the following periods:

    a. Claimant was temporarily totally disabled from 14 Jun 02 to 22 Oct 02, 10 Oct 04 to 24 Oct 04, and 26 Oct 04 to 29 Apr 05.

    b. He was permanently partially disabled from 29 Apr 05 to at least 24 Dec 05.

9. Claimant remains permanently partially disabled from 24 Dec 05, to present and continuing.

10. Employer shall pay Claimant permanent partial disability compensation, from 24 Dec 05 to present and continuing, based on an average weekly wage of $591.20 and weekly post injury earning capacity of $296.40.

11. Employer shall receive credit for all compensation heretofore paid, as and when paid.

12. Employer shall pay interest on any sums determined to be due and owing at the rate provided by 28 U.S.C. § 1961 (1982).[85]

13. The district director will perform all computations to determine specific amounts based on and consistent with the findings and order herein.

14. Claimant's Counsel is hereby allowed thirty (30) days from the date of service of this decision by the District Director to submit an application for attorney's fees.[86] A service sheet showing that service has been made on all parties, including the Claimant, must accompany the petition. Parties have twenty (20) days following the receipt of such application within which to file any objections thereto. In the

[85] Effective February 27, 2001, this interest rate is based on a weekly average one-year constant maturity Treasury yield for the calendar week preceding the date of service of this Decision and Order by the District Director. This order incorporates by reference this statute and provides for its specific administrative application by the District Director. *Grant v. Portland Stevedoring Co., et al*., 16 BRBS 267 (1984).

[86] Counsel for Claimant should be aware that an attorney's fee award approved by an administrative law judge compensates only the hours of work expended between the close of the informal conference proceedings and the issuance of the administrative law judge's Decision and Order. *Revoir v. General Dynamics Corp.*, 12 BRBS 524 (1980). The Board has determined that the letter of referral of the case from the District Director to the Office of the Administrative Law Judges provides the clearest indication of the date when informal proceedings terminate. *Miller v. Prolerized New England Co.*, 14 BRBS 811, 813 (1981), *aff'd*, 691 F.2d 45 (1st Cir. 1982). Thus, Counsel for Claimant is entitled to a fee award for services rendered after **6 Jul 05**, the date this matter was referred from the District Director.

event Employer elects to file any objections to said application it must serve a copy on Claimant's counsel, who shall then have fifteen days from service to file an answer thereto.

So ORDERED.

A

PATRICK M. ROSENOW
Administrative Law Judge